Regional Workgroup Minutes

Meeting #3
September 27, 2011
10:00 am to 3:15 pm
Supreme Court Chambers
State Capitol Building, Des Moines, IA

MINUTES

Attendance

Workgroup Members: Jane Arnold, Robert Brownell, Mary Chavez, Tom Eachus, Lori Elam, Jack Guenthner, David Hudson, Sarah Kaufman, Linda Langston, Bob Lincoln, Charles Palmer, Mary Vavroch, Suzanne Watson, Jack Willey

Legislative Representation: Renee Schulte, State Representative, House District 37 (Linn County) and Co-chair of the Legislative Interim Committee on MHDS Redesign; Jack Hatch, State Senator, District 33 (Polk County) and Co-chair of the Legislative Interim Committee on MHDS Redesign; Joel Fry, State Representative, House District 95 (Clark, Decatur and Union Counties)

Facilitator: Steve Day, Technical Assistance Collaborative (TAC)

DHS Staff: Theresa Armstrong, Julie Jetter, Robyn Wilson, Brian Wines

Other Attendees:

Joel Wulf	
Kristen Artley	Johnson County Mental Health & Disability Services
Bob Bacon	Center for Disabilities and Development (CDD)
Jennifer Bauer	Candeo
Josh Bronsink	Senate Republican Caucus
Dawn Clark	Wapello County
Shelly Chandler	Iowa Association of Community Providers
Karen Walters-Crammond	Polk County Health Services
Diane Diamond	DHS Targeted Case Management
Glenda Farrier	CASS Incorporated
Kyle Frette	Easter Seals of Iowa
Kay Grotheo	AMOS MH
Linda Hinton	Iowa State Association of Counties (ISAC)
Michelle Honghton	Lexington Place

Ken Hyndman	Des Moines County CPC Administrator
Kathy Jordan	DHS Targeted Case Management
Steven Kerber	Appanoose County
Mary Murphy	SE Iowa Case Management
Brice Oakley	Iowa Alliance of CMHCs
Valerie Owens	Healthy Connections
Kelley Pennington	Magellan Health
Sandi Hurtado-Peters	Department of Management (DOM)
Steven Roberts	Disability Rights Iowa
Jim Rixner	Siouxland CMHC
Joe Sample	Iowa Department on Aging (IDA)
Kim Scorza	Seasons Center
Lisa Sienen	United Way
Rik Shannon	Iowa Developmental Disabilities Council
Deb Eckerman Slack	ISAC County Case Management
Julie Smith	Iowa Health System
Chris Sparks	Exceptional Persons Inc
Dave Sprost	BMS.
Wade Stierwalt	Scott County
Jennifer Vitko	Wapello County CPC Administrator
Dion Williams	Systems Unlimited

Agenda

Agenda Topics:

- Re-cap of Meeting Two: Review and Comments on Minutes
- Overview of the Potential Functions of Region
- Discussion of Governance Options

INTRODUCTORY REMARKS BY CHAIR CHUCK PALMER

Director Palmer gave an overview of the Consumer Input meetings held so far. We are getting more questions than responses. Some of the issues being brought up:

- People are falling through the cracks.
- 'Local level input', what does this really mean?
    - Travel farther to get something in our own community today?
- Funding, bringing the county dollar into the mix. How does that work?
    - The need for county dollars will be evident as the funding situation moves forward this year.
    - There is a stewardship responsibility of supervisors when it comes to those dollars.

Governance is on the table and we are open to other parties doing that as well.

Director Palmer and others met with Senator Hatch, Representatives Schulte and Fry prior to regional workgroup meeting and discussed expectations for the interim committee. The legislatures are expressing the need for specificity, not a general report

with general recommendations. This workgroup will need to present recommendations - maybe not always coming to consensus - and provide rationale for multiple stands. Standing silent does not let the voice be heard, it just 'kicks the can' down the road and this workgroup will have defaulted on their responsibility. Director Palmer has asked Steve and Kevin to push and drive the workgroups to be specific in their recommendations.

REMARKS BY LEGISLATORS

Representative Joel Fry remarked that he has attended different workgroups and the process has been neat to watch. The key issue seems to be funding of the system. He thanked everyone for participating on this workgroup and helping with this process.

Representative Schulte remarked that she is excited to talk about property taxes. She also thanked the workgroup for their hard work.

Senator Hatch remarked that the next two meetings will have a dramatic effect on the final product of the workgroup. This workgroup will not be doing a report but direct recommendations, as a specific as you can get, will be the best. The four caucuses agree to work together and create a system based on your deliberations. Thank you and I hope we have made this as clear as possible; you are the designers of the system.

STEVE DAY REMARKS

I appreciate your patience; we have added an hour to the meetings.

Things to be thinking about today:

- What should a region be held accountable for?
    - Administrative as opposed to the direct service?
- Efficiency to the system…how do you create something that brings maximum value to the system?
- How do you continue to have local benefits and have an efficient region?
- What tools does a region need to have to do business and have accountability.
- How does DHS contract with the region and have accountability from the top down?
- And also have accountability from the bottom up: Consumers/communities need to show benefit from the providers.
- A region may be thought of as something like mini-Managed Care Organizations.
    - The region will use many of the same tools.
    - Regions will have many of the same accountability issues.

The degree to each of you speak up will help come to consensus. Please bring up questions and issues; we need a full discussion of these things.

HOW ARE FUNDS POOLED AND HOW ARE THE COUNTY DOLLARS ON HOW THE MONEY IS AGGREGATED AND MANAGED?

An example of County Social Services by Bob Lincoln:
Fiscal year 2011 was first year of a collective fund for the five counties in CSS. A fund was established and Butler County agreed to be fiscal agent (Butler County MHDD budget went from 1.4 million to 25 million dollars). All state and federal revenue is deposited directly into the Butler county collective account and each county transfers the property taxes into the collective account. Payroll and administrative expenses for each county's employees (of CSS) are paid by the member county and reimbursed quarterly by the Butler County collective account. CSS made the deliberate decision to move the business programs (example: Country View, the skilled nursing facility in Black Hawk County, Mitchell County Care Facility, Targeted Case Management) out of the MHDD fund and at the suggestion of Andy Nielsen from the state auditors office moved them into enterprise funds and then charge the MHDD fund on a fee for service. This change made the collective account, as much as possible, a pure purchase of service program, creating more integrity in the program. The budget went from $32 million to $24 million.

Question: Do you handle the Medicaid money too?

- No, just the Medicaid match. We are not managing anything different.

Question: Who does the admin with DHS? Does that become the function of one particular county? With the completion of this year you will actually be able to show how you manage within your department all the bills coming to you. Will you bill back the counties?

- I (Bob Lincoln) am the administrator and am accountable. This will be the first year that we submit one consolidated annual report. What we think we gained is efficiency; we looked at our staff, and consolidated operations. We have specialized within the staff: adjudication of bills, preparation of claims, funding authorizations etc. We can have staff located in county offices but doing the work for the consortium. Example: Funding requests goes through Black Hawk County, and Karen authorizes the funding. The funding authorization is then forwarded to Cerro Gordo County to adjudicate the claims and then sends the warrants to Butler County. There has been a reduction in staffing needs because of efficiencies.

Question: I am a supervisor and I have levied money in my county for MHDD services, how do I assure my local taxpayers that this money is being spent properly and for the people of my county?

- All the counties have to levy the maximum allowable amount. We are giving some protection to all the counties. We are asking the counties to think of this as a premium being paid and in return they are to expect their county to be safe. Even though we can use the data base (CSN: County Systems Network) to drill down to each nickel and dime and track an expenditure to a county, it really is not the mindset we want to use. This is a collaborative. Butler County is an auditor for the CSS. As we get into the tax support issue, what I hear from the county supervisors is that they want some investment in the system, for local control.

Question: How does each county pay for the administrative piece?

- People are doing multiple programs. Example: I (Bob Lincoln) am not full time for CSS. I also do four general assistance programs. I handle the substance abuse hospitalizations for a county, etc. We have people who are doing multiple programs, so all the Full Time Equivalents are actually piece work. Hardly anyone is full time for CSS. It comes down to: "What are resources and how can we best use them?"

Question: How do you handle rate negotiations? If you have an established rate that not all counties agree on, how do you assure that one county is not being shorted?

- Ultimately it is up to the 28E board members to resolve that issue. This issue has not come up for CSS to this point. Basically rates are driven by Medicaid system and the county cannot negotiate a rate lower than the Medicaid rate. If the board has any reason or concern, the Butler County fiscal agent can act as an auditor for the county (in question). All current applications, service and funding data is in the system.
- Suzanne Watson: The county is able to negotiate rates for Pre-vocational services, Day Habilitation services, etc. If IME sets those rates, there is the potential for the rates to go up substantially, and this rate setting process could be enhanced by the regions.
- Robert Brownell: If counties have a part in the Medicaid process, it provides for function/audit of the program.

Question: Black Hawk and Cerro Gordo Counties are somewhat larger counties, with significantly different populations between the smaller and larger counties. Linn County is looking at administrative issues such as: the smaller counties may have part time employees, how representation will happen, and full time versus part time staffing needs. A lot of the smaller counties around actually come to us for services, data programs like CSN. How do we work this out? Can you reflect on this?

- What you are referring to is buy in and relationships to make things work. All of this is attributed to the leadership of the Boards of Supervisors. My charge is to reinforce everyday that we made the right decision. The county office is the management unit, and has a 'franchise' or service unit. We try to balance preserving the local office and/or control and leveraging the other duties on a regional basis. It is our intention to look at the greater good. Remember, it has taken me 15 years to get to this point.

Question: How do you go about establishing a group? People are talking about ending fund balances, etc.

- The funding game…we are economic animals. The funding formula can motivate you do things that you would not ordinarily do, and it did reinforce the taking of a county with a negative FB to lower the ending fund balances of the entire group. We try to do the best we can with the dollars we have available, but it is a guess every year. We (the CSS counties) need to know early on what funding is available, so we can make funding decisions.

Question: Levy rate; how would that work? (Equity and Equality)

- My (Bob Lincoln) presumption is this (the county levy) is only a piece of the funding. The State dollars would equalize this.

GOVERNANCE DISCUSSION

County size: How do you handle the situation of a disproportionately larger county?

- Linda Langston: We actually have some good relationships with surrounding counties. We have not come to a resolution but if Johnson and Linn would be picking up more of the administration, we have the capacity to do that. The smaller counties still want to have a say in the system and there is a significant amount of concern the larger counties would be a minority on the 28E board. The discussion has come up of weighted votes based on county size, but this is troubling and has caused issues on other boards. Membership on the 28E board does not have to be elected officials.
- Robert Brownell: I think I really lean towards one person/one vote. Weighted vote's causes hostility. On some boards, weighted votes are triggered by specific issues. Levy rate versus a dollar cap would help relieve some of the tension.

STEVE DAY: ABSTRACT QUESTION: In order to be a region, do the county dollars actually have to be pooled? Are there places out there in partnership that do not pool their dollars?

- The CSN allows that to happen. One person could go in and pay all the bills for the counties in the consortium.
- It goes back to fund balances, having a positive one versus a negative one.
- Clients' needs should drive the funding.
- Legal settlement is going away and service funding will be based on residency.
- How equal is access to the funds between counties and/or the benefit of having a 'pool'?
- If the size of the system has to be reduced, counties may think they can do better by themselves.

Question: If the funds are pooled how do you handle it if one county wants to provide something and another county in the 'pool' does not want it?

- In CSS, we do things because we think they are more efficient and effective. The smaller counties are able to have things available that are normally only available in larger counties. No matter what, you need critical mass for some services to be provided. Under the regional system, the smaller counties would have access to some services in the larger city(ies) in the region.

Question: Tom Eachus, you are provider in the CSS region, what are your thoughts?

- We have advocated for mobile crisis and have more need in Waterloo and Black Hawk County than the smaller counties. Grundy Center won't have a 24/7 team available. But we do have an eligibility system and rate setting that is equal, and a seamless system for services. Not all that much has changed in the operation of the business, but the CSS has allowed additional flexibility.

What about providers?

- All the players need to be at the table. You will lose the provider voice.
- The region needs the providers and the providers need the funding of the region. It all goes back to relationships.
- There are other types of participation for providers, consumers, families and other advocates.
- If providers are on the governance board, it could create a conflict of interest, with contracting and rate negotiations.
- Elected officials need to be responsible for those dollars (Legislative perspective).
- The other players would be key in putting the management plan together. It would be a key role for them.
- Elected officials could be on the governance board and stakeholders could make up steering committees.
- Need to lean on provider's expertise/strengths. Example: Hospitalization issues, transporting patients across the state.

Question: Should local counties have a stake in the game? Have a contribution in the pool?

- Counties should have a contribution in the process, contribution to the pool. This is still an issue in the process. Small counties may have some issues with regionalization, but they need the access to the services. Getting everyone to the table takes time, crafting the 28E takes time and dealing with the details takes time. There needs to be some level of respect for economic changes, provider changes, board of supervisor changes, etc.
- If it went to the state only, and only Medicaid services were provided, it would lower the bar. County dollars could be used for non-Medicaid services only - the 'core +' or 'enhanced' services in the region. In essence, this could cause inequity across the state. There needs to be local dollars in the system.

Question: Is it local control over county levy dollars, or local control over managed dollars?

- We need to look at the larger global picture.
- More to the financial reality, this ultimately becomes very significantly linked to property tax reform. If the rate is capped, it may hinder counties providing 'core +' services. If the MHDD funds go away and a county can only grow its general levy by 2% it will cause a problem to the larger counties.
- Go back to early statement, if a region should have a large shortfall in any particular year, where does it go? Will there/should there be the ability for the state to cover it? Risk pool? Would local counties be expected to cover the shortfall?
- You could have one year that there is a strain on the pool, need a pressure relief valve. A risk pool could be formed by contributions of the regions and state.

GOVERNANCE SUMMARIZATION

1. 28-E is a mechanism for sharing/pooling funds, straightforward governance.
2. The perception is that the consumer drives the funding. This is a conceptual leap of using county dollars to leverage dollars on a person-centered basis.
3. Pooling of resources. ACTUAL versus VIRTUAL.
    a. Actual: There would be a repository for all revenues to go to. (Like Butler County for the CSS region.)
    b. Virtual: Amalgamate a process to be consistent. The accounting for the dollars stays in each county. How the money is being spent, provider contract, core services, etc. would need to be agreed upon.
4. Governance for the purposes of governance: Supervisors are in charge of governance, and the 28E would specify that the Board of Supervisors is represented directly, or they nominate someone. This is a partnership, one county one vote.
5. 1 county=1 vote. There would need to be balance on the board. Larger counties sharing power with smaller counties. Weighted voting may cause issues.
6. Clear input and advisory structure with formal obligations to people (providers, consumers and other advocates) they are in partnership.
7. Counties need to have a stake/contribution in the process to have a meaningful roll. Counties should be bringing resources to the region.

*Another model: The 28E would construct an actual council that becomes the regional board:

In order to be held accountable/add value to the system, regions need to have certain functions and efficiencies or it wouldn't be able to have influence on the regional structure. The State of Iowa is going to purchase regional coordination and services for people with disabilities. What will they buy and how do they hold the regions accountable? You need to define functions the region will provide and how these functions will be purchased.

Regional Planning: Management plan/strategic plan: This is a point in time aspect, and should provide the following information:

- *Describe the geographic region.*
    - Communities served
    - Socio-demographics of the citizens to be served
    - Locations of major service centers, hospitals, etc.
    - Identification of central administrative entity for the region (single point of accountability)
    - Description of the governance board of the regional administrative entity

NOTE: Financial/clinical will be statewide mandate, not the decision of the region.

- Description of the roles of consumers and families in the design, operation and evaluation of regional structures
- Specification of people to be served
- Specification of services to be provided
- Specifications of clinical/level of care criteria for accessing each core and optional services
- Customer relations
- Designation of Access Points:
    - SF525 is clear on this. We will reserve time later on in the agenda. Specify what access points are, who they are, where they are.
    - An access point is not necessarily a place; it is a person. If we do away with the CPC and just have a regional entity, we like knowing that somebody (CPC) knows the people, what services, etc., are needed.
    - Jail is an access point.
    - There needs to be the ability to combine data with hospitals, etc. to plan for people leaving those services.
    - Look behind activity will assure equal care.
    - Key is equal access; make regional framework look identical, will help determine what works.
    - Do things consistently, same access and entry into the system, across all regions.
    - Define an access point. It could just be an application or it could do some sort of service, determine eligibility, etc.
    - The underlying principle is ‘No wrong door’. Don’t want to lose the consumer.
    - Access point implies geography. What we are talking about is an Access PROCESS. Everybody needs to be the starting point in the process, so we don’t lose people.
    - The provider’s responsibility is to make sure they start the process and hand off the consumer.
    - An access point could be a phone number.
    - There needs to be standardization of the process maybe, but don’t see it changing from what they are now.
    - Crisis call system may be regional.
    - Talking about definition and the process. We don’t want to redefine something that is already happening out there. We need clarity about what access point does.
- Designation of TCM
- Plan for Core Services:
    - As with the eligibility criteria, there will be standard core services, but the plan will describe how they will be made available. Remember: not every region will have every core service available tomorrow and some regions will have services that are not core services. Plan needs to define steps to be taken to equalize the inequity. Move towards consistency.

    - If the core services are available in an adjoining region, could they be used by another region? You may want to have arrangements for core services that are not available in your region.
    - When you think about core services and various provider networks, some are much more expensive in some areas of the state. You may be putting your region at risk.
    - If you go to a more consistent definition of services, you are giving providers a better chance providing those services at a fair price
- Plan for Optional Services:
    - Allow the regions to have Core +, if they are able to demonstrate the need.
    - Tension has arisen between System of Care model versus core service. May bring in important services that are not 'core' to the consumers at large, but is core to the individual. Person centered.
    - Had the opportunity in the children's workgroup of putting child and family in the center of the equation – what is actually needed for that child and family. Adult system conversations have been a little more around traditional services, ACT, CSP…ultimately want to try to get at both.
    - Supports driven mode: What does a person need to live in the community? Some services are core, psych., hospital, med management, etc. The definition of community support services can be a variety of services…core service headings/definitions that are general will allow that.
    - Evidence based practices need to be looked at. Don't use optional to cover legacy services that may not have the evidence based back up.
    - Linda Langston: One thing we do is sheltered workshop. We are loath to phase that out, but interested in pushing that to the enterprise fund. How do we build some kind of commonality of our IT systems? If we gather data that is common enough, do we have the system to analyze the data we have? How does the documentation piece work? The whole planning process where you are shifting your program over to evidence based practices, needs to be data driven.
    - Most counties do still do sheltered work.
    - Data and collecting data: the CSN project will have 97% of the data, and 95 counties will be on board. SF525 does have a group to get together for the data people.
    - We have talked about the data requirements set forth in SF525, but membership on this group needs to be larger than the three entities in SF525 and the relationship with health homes needs to be addressed.

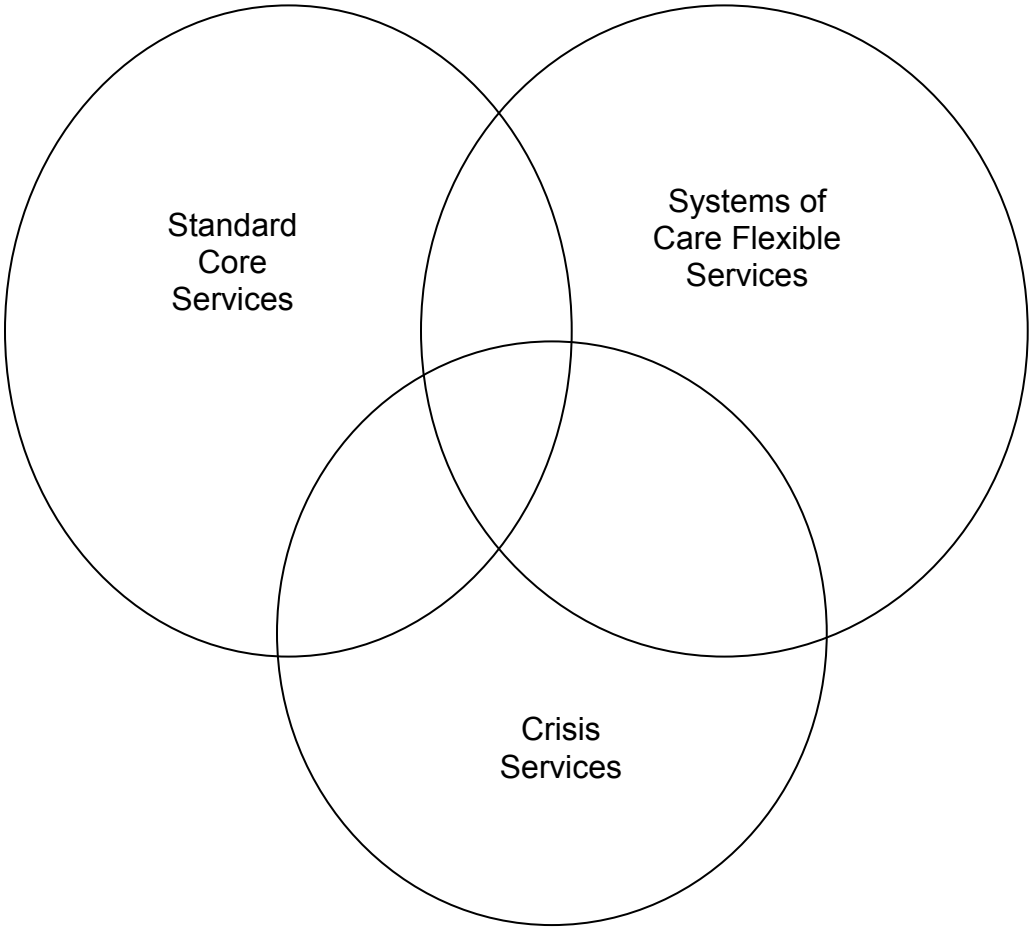
- There is a whole issue of level of care/clinical criteria and who would be eligible to use those services.
    - Assessment tools: The adult ID group is looking at SIS and the adult MH group is looking at LOCUS.

- Customer relations: How do we know when to ask for services? Where do we go? Other supports: churches, etc. Consumer advocacy groups have that information and linkages.
    - Engagement: informative obligation to find people and keep them engaged. Many times this does not get the appropriate time needed to fully identify what it is and how to do it.
    - Information dissemination: How is the information/referrals/out reach related to other ethnic groups, non English speaking persons? Needs to be formatted for the people in the region. Regional plans need to spell it out.
- Assure effective crisis prevention, response and resolution. Describe how it works, not necessarily have a provider to do all.
    - Where is the step down capacity going to be?
    - Rural areas: how do people access crisis services/crisis response services?
    - What does Mobile Crisis look like? Looks different according to what your needs are. It may be a way to access services. The reality of jail diversion, smaller communities have informal networks, but that is not going to be true in Des Moines or Cedar Rapids. They have a different set of relationships based on need. The Court workgroup has started looking at this and passed it off to adult MH workgroup. They are looking at several models of crisis stabilization/jail diversion, and how it looks different between urban and rural. Parameters will be set up, but region will need to be able to form it to their needs.

STEVE DAY: Diagram now has three circles.

- Crisis systems have elements of core services, and system of care services, and how they fit together. Components need to be described beyond the service components. Crisis response/diversion is not fully funded by Medicaid, and can't be run with fee for services model. Crisis services are funded like the 'Fire house model': always eligible, but not always busy.
    - Have to work together or it won't survive.
    - Can't do one county at a time, needs to be multiple counties/larger areas.

Diagram of Core Services, Systems of Care and Crisis Services



- Provider network formation and management:
    - Name of providers of each core and optional service for each sub-population
    - Specify the methods and criteria for selecting providers for the network
        - Use of state certification/credentialing processes and criteria
        - Use of national accreditation status (deeming)
        - Use of statewide uniform cost reports and rate setting mechanisms
    - This is for the ease of the providers. All their costs would go on one report.
    - 2/3's of the counties are using a uniform cost report now. Trying to get on standardized report, one standardized accreditation, and one standardized way of doing rate negotiations/settings.
    - Maybe de-linking with Medicaid. I think we may see some efficiency. Look at bundling costs, systems of care, etc.
    - Provider data submission requirements.
- Assurance of provider network sufficiency
- Methods of provider billing and payment
    - Do regions have discretion to admitting to the regional network? Any willing provider who provides Medicaid services, are in by default OR a region can chose the providers they will work with.
    - I think the region should get to choose. Having more providers does not necessarily improve the systems of care.
    - The only concern is that sometimes people don't want to work with a provider. Sometimes the private provider does a better job. It should be consumer choice.
    - I agree there is an important role for providers, but as an advocate for consumers, if they don't have a choice of the providers they use, they will not get better. Recovery includes choice.
    - In order for bundling to work, the providers need to be on the governance board. If we don't let them on, we are developing a linear process.
    - What I see more is that we have clients that no provider wants.

Steve Day: This not a black and white issue, nor should it be. Development of the relationships and partnerships takes time. While, having said that, consumers need choice and providers need be able to change. You want to make sure that you don't get too many providers that they cannot be sustain or have runaway providers; you want sufficient payment, high quality and performance not personal animosity.

- Provider rate setting
- Provider certification
- Grievances and Appeals
- Quality Management/Quality Improvement
    - Lays out specific activities for every three years, or so.

    - Contains a higher level of detail.
    - Related to the process of care, moving through the system, timely assessments, etc.
    - Majority of people when they are coming into the system have to wait 3 months to see a mental health professional. This is a process issue and needs to be addressed.
    - Must also focus on the outcomes of treatments.
    - Look at what drives of systems change and transformation, one of the best drivers is the quality management/improvement. How this is actually working. What kinds of outcomes are happening? Over time things change. The quality improvement process helps drive that in the right direction.
    - Supportive of this process, but we don't have the dollars to support the data system we need to track it. There is going to be the need to invest in order to get to the quality management.
    - If you are going to have new resources, you can allocate them, but you need to look at how you are using resources to make sure you are spending your dollars in the most effective way.
- Payment of providers
- Funds accounting and Financial forecasting:
    - The region must be able to account for funds and forecast financial resources. There is a fixed pool of resources and every year the region will have a fixed amount of resources. If done right, the region delivers as many services to as many clients as they can, to have as close to a zero balance as possible, at the end of the year. There is as much danger of under serving as there is over serving.
    - Do MCO's actually do that? Yes.
    - What happens if they overspend? They are at risk. They either draw on their fund balance or go to the risk pool. You want to make sure that doesn't happen.
    - You also want to make sure that you don't reward the managed care organization for growing a fund balance.
    - The Magellan agreement is only allowed a percentage for administration and the remaining funds go to community development programs.
    - What we are really talking about is program integrity. There are huge issues around not being able to do that. If you don't get that money out the door there is not enough money for cash flow.
    - The region doesn't have the ability to oversee a Managed Care Organization, does the state auditor do that or who? The state insurance commission can look at it, and make predictions if a MCO would be able to survive.
    - Is the goal to have the administration of claims by region, or a statewide entity? Setting out the function of the region, the region has the first shot, but legislation could change that. There may be back door functions that region does not want to do, and could leave more money for services. We start with having regions be the complete services program, unless there is region decides not to. Looking at efficiency of scale.

    - Bob Lincoln: We had to scrub the process to get it right. The first tiers of providers are the local small providers. Encumbrance of funds may lead to the end of the world. You need to look at the historic expenditures and use that when encumbering. The real challenge is forecasting the revenues. Counties certify their budgets in March, and legislation of revenues from the state won't be available until much later. Environment changes cause revenue management changes, which then change expectations for programs.
    - Back to the revenue portion, seems it might behoove the legislature to look at the 2 or 3-year level of funding. The funding process causes problems.
    - One thing our stakeholders have talked about: allocating a certain number of institutional beds to the region, for those folks who are hard to serve etc.
- Data collection and reporting
- Interagency collaboration
- Grievances and appeals

Outcome and performance measures will be statewide. There will be some ability to pick which measures the region will use. The region may use it for Quality Management implementation. Also, there will most likely be some system performance indicators to which regions can be held accountable. Regions are going to have to show how they are going to meet the requirements of the outcomes. How does the region intend to meet its own standards?

A region needs to describe how the business functions happen, i.e. contracting, payment, etc. Claims adjudication needs to happen. Reliable consistent mechanisms are available. Money needs to get to the right provider, for the right services, for the right client.

What is the correct list of functions to be included within the defined scope of responsibility and accountability for regions?

- Time to look at how we administer programs (waivers) with case management.
- Look at how optional services are handled.
- Language is extremely important. Need to look at this carefully.
- Need the parameters. Crisis could look different in every region.
- Look at something that is like systems of care. It is what the other workgroups are using for optional. Change the name.
- Need specific discussion about this and definitions.
- I have a problem with the three provider functions. It seems overreaching. Everything else is ok, but I am not sure about this.
- There needs to be an explanation of what the provider functions are now.
- This is an inventory issue. These are the providers who we pay.
- The state certifies providers now.
- The uniform cost report needs to stay in here.

- Should this (uniform cost report) be changed to provider reimbursement?
- We need to have some capacity to certify non-traditional providers. Can we pay somebody who is not certified by the state?
- There needs to be due diligence.
- Flexible function at the regional level. Systems of Care process that is unique and functional.

What value do you want people to add to the system?

- Linda Langston: We do this now. We will send you what we do now.
- If we are going to look at measurements, we need to look at statewide measurements.
- Adopted by the state and legislature for all regions. Indicators of access, paying providers, etc.
- Isn't that what we did in the adult workgroup? Yes.
- Benchmarks need to be set by the state.
- You will want to look at the variations between regions.
- Consumer and family outcomes as regional goals? Each family is individual and to say that each region would use this as an outcome? It could be patient satisfaction across the system, community tenure, reduction in hospitalizations, etc., would aggregate at the regional level. It may mean that different benchmarks be set for different regions.
- I would like to see the human requirements measured.
- Standards need to be in place for participation.
- We would like to see other examples and we need to think about this.
- Bureaucratic issues: ratio between administrations to service expenses. MCO by federal law is less than 15%. You may want to have an indicator to look at the degree that the public dollar goes to administration.
- How are we going to address the issue of how to cover the mobile clients, people will be moving from region to region? We are going to need to have a process in place to follow their funding.

STEVE DAY: Next meeting we need to discuss the Appeal process.

- Informal versus formal process. The formal process would be consistent across regions.

Would the group entertain starting a half hour earlier and leaving a half hour earlier allowing for persons with a long drive home? No objections: The regional workgroup will be starting one half hour earlier and leaving one half hour earlier.

THE GROUP HAS REACHED CONSENSUS ON THE FOLLOWING TOPICS:

1. Discussion of Funds Pooling

There was consensus that:

- County funds could be pooled into one account in a fashion such as described by Bob Lincoln; and/or
- Funds could be pooled "virtually" by agreement of participating counties operating under one regional plan with common spending principles, services, etc.
- The primary issue for funds pooling relates to County levy funds – and maintaining county stewardship of these funds – not to state general fund allocations to counties or regions.

It should be noted that the County members in Bob Lincoln's consortium think of themselves as "buying in to an insurance plan for their citizens" rather than as expending county levy dollars on specific services for specific consumers within each county. This is a very different mind-set, and it was suggested that it would not be necessary or perhaps even possible in the early stages for regional formation.

2. Discussion of County governance of regions

- There seemed to be strong consensus that if county levy funds are to be contributed to and managed by regions, then county supervisors would have to be the primary participants in regional entity governing boards.
- There was relatively strong consensus that proportional representation or proportional voting would be too complicated and could also be a disincentive for smaller counties to participate in regions. It was generally felt that the principle of "one county – one vote" should be the rule. However, after further discussion some members asked for future reconsideration of this issue, perhaps to include some form of weighted voting on critical financing issues.
- There was consensus (albeit not unanimous) that provider membership on the governing board could create conflicts of interest. It is typical for providers to be included in stakeholder advisory councils, etc., but not on the governing body of the entity that must allocate resources and monitor provider performance.
- There was discussion of potential consumer family membership on the governing boards of the regions. TAC noted that there are two options for this: (1) to have the supervisors that constitute the governing body appoint some consumer/family members to the board; or (2) to establish a consumer/family advisory council, and then have that group elect some (a few) of its members to serve on the governing board. No closure was reached on this issue.

3. **County stake in the Region and Governing Board**
    - There seemed to be consensus that counties should have some financial stake in the regions in order to make their participation meaningful. While this seemed to reference county levy funds to be pooled (actually or virtually) within a region, this was not made explicit.

4. **Discussion of Core Services and Systems of Care**
    - It was noted that strict or narrow definitions of core services might exclude the more flexible approaches to service modalities implied by a systems of care approach. There seemed to be consensus that certain core services had to be present in a regional system, and that systems of care can and should be constructed partially of defined core services. The same discussion occurred with respect to crisis services. The workgroup seemed to agree that core services, systems of care, and crisis services are three partially overlapping circles.
    - There was discussion but no consensus on optional, or core+, services. Some felt that regions should have discretion to add optional services if resources were available. Others thought that no optional services should be included, to assure that equity of service access and consistency of service definitions would be maintained statewide. TAC noted that core+ or optional services should not be included to maintain service modalities for which there is no evidence base, even if those service types are currently in county management plans. This recommendation was not universally agreed to by the workgroup.

5. **There was a request for clear definitions of elements of the regional system and management plan – such as the term "access points."**
    - It was pointed out that many of the necessary definitions are already included in the DHS requirements for county management plans.

The workgroup discussed the three tables included at the end of TAC's issue paper for this session of the workgroup. We believe the following represents the consensus reached in these discussions:

- Note:
  Red = new material added by the group
  ~~Strikethrough~~ = material deleted by the group

1. What is the correct list of functions to be included within the defined scope of responsibility and accountability for regions?

Function	Yes	No	Comments
Regional Planning	X		
Designation of Access Points	X		
Designation of TCM	X		Modalities and providers of TCM to be defined by DHS, not the regions
Designation of service management for non-Medicaid people/services	X		
Plan for Core Services	X		
Plan for ~~Optional Services~~ Systems of Care	X		
Assure effective crisis prevention, response and resolution	X		
Provider network formation and management	X		
Provider ~~rate setting~~ reimbursement approaches for non fee-for-service modalities	X		Must use standard state uniform cost report as applicable
Provider certification	X	X	Not for state licensed or certified providers, but yes for non-traditional and non-licensed providers
Grievances and Appeals	X		Note role of Administrative Law Judges, Appeals Board
Quality Management/Quality Improvement	X		
Assurance of payment of providers	X		
Funds accounting	X		
Financial forecasting	X		
Data collection and reporting	X		
Interagency collaboration	X		
~~Grievances and appeals~~			

2. What should be the primary domains for performance measurement and accountability for regions? (Note: examples of performance indicators will be supplied and posted on the DHS web site before the next meeting)

Performance Domain	Yes	No	Comments
Attainment of consumer and family outcomes	X		Reported and profiled at the regional level
Attainment of system performance outcomes	X		Reported and profiled at the regional level
Attainment of defined quality standards	X		
Ease of access to core services	X		
Effective and consistent operations of TCM	X		Must be monitored by DHS/IME, too
Provider network sufficiency	X		
Successful crisis prevention and diversion	X		
Evidence of continuous quality improvement of all regional functions, including provider quality and effectiveness and workforce development	X		
Timely and accurate payment of providers	X		
Accurate funds management	X		
Compliance with applicable state regulations and the performance contract between the state and the regions	X		
Timely and effective resolution of grievances and appeals	X		

3. In what functional areas of responsibility and responsibility should Regions have discretion?

Function	Regional discretion within state standards	No discretion – must be consistent statewide	Comments
Regional Planning	X		Must follow DHS guidelines/topic areas
Designation of Access Points	X		
Designation of TCM	X		Only can designate DHS/IME approved providers
Plan for Core Services		X	Core services will be defined by DHS and all regions will have to assure that core services are consistently and equitably available within each region
Plan for Optional Services	?		To be discussed further
Assure effective crisis prevention, response and resolution	X		
Provider network formation and management	X		
Provider reimbursement	X		Must use standard state uniform cost report
Provider certification		X	Except for non-traditional, non Medicaid services and providers
Grievances	X		
Appeals		X	
Quality Management/Quality Improvement	X		
Payment of providers		X	
Funds accounting		X	
Financial forecasting	X		
Data collection and reporting		X	
Interagency collaboration	X		

PUBLIC COMMENT

Comment: The designation of Case Management/Services Management – it is a conflict of interest if the program is supervised by the funder. In terms of quality Improvement, this doesn't seem to be an issue when talking about providers and all of the quality assurance/improvement that they need to do, so it should not be an issue for the funders. Funders should have to do it, too. In regards to rate setting/cost reporting: this is very important. There are rules and laws in place but no mechanism to appeal. When you have providers who are also employees of county system, you create a conflict of interest and an issue of accountability. Think about the issue of the region are not meeting the needs of the people, what is the 'stick' and what will the standards be? An appeal process states that the decision of the Administrative Law Judge is final but the Director of the department of Human Services can overturn that decision. This is a conflict. There needs to be state wide benchmarks, while allowing flexibility for regional variations. There needs to be Quality Management

Comment: Concerned about optional services and is not sure what it means. Feels as though the cart has been put before horse. Please wait until the core services are defined. Optional services should be parked in the lot. Depending on definitions, I could lose nursing, prescriptions, supported community living services paid 100% by county. The whole question of medications, both here and adult mental health group – I am concerned on how we prescribe, fund, etc. Somewhere in these discussions, medications need to be addressed. Is there a possibility for fair funding for prescriptions? We need to be connected with primary care.

Comment: You have not developed a very clear roadmap for the development of these regions. Please remember that the CMHC's will be regionalized during this process. There will be a need to discuss amongst them how to put associations together to meet regional needs. There need s to be a clear roadmap. You need to think about mechanism for resolving: orphan counties, sought after counties, and SF525 CMHC catchment areas. Eventually the dept. would resolve issues. What happens if the state does an RFP and the regional bid fails? How do you handle dividing and rearranging the counties.

Comment: Our mobile crisis team, located at the Des Moines police department (a policeman goes with the team for safety issues, then leave when the case is decided to be safe) had 2,000 calls last year, 65% of which were resolved on site. We look at the program on a quarterly basis for the outcome of calls. No more that 3% the calls end up in jail, more like 1.5-2%. This program provides for on

the job training for police officers. Previously, Crisis Intervention Training was pushed for law enforcement officers, but now law enforcement is requesting it. The mobile crisis program has provided growth in many officers.

With regard to provider network formation and management: If there is no role with Medicaid, there will be no network. County pays 100% for persons not eligible for Medicaid. Consider adding Medicaid management to the list.

Coordination among regions - we get together as counties now to share ideas, swap stories, compare notes, to help each other along.

Create and expand evidence base practices. Break away from boxes of services. Systems of Care…how do we handle core services with individuals? Creative flexibility for approaches to care, makes a difference for people going forward in recovery or going back.

Targeted Case Management is a function not service. We were pushed into brokerage model in the 80's. Integrated services agencies handle the coordination function within the program. People are going to places they want to go, work, community, etc., people do best with the creative services, and you don't need a broker to do that. The more integrated case management services is to the person the better for the client.

Encourage the governance be flexible. Right now the message is you are grown up to decide who to play with, but we will tell you how to play. There is a mixed message.

Comment: Regionalization: in order for this to work out well, there will need to be a paradigm shift from counties to region. Other models of governance: Have district representatives and at large representatives, counties would share some representatives and some at large persons. Not all supervisors are chosen because of the MHDS knowledge. If you elect the representatives, it could be persons w/disabilities, advocates.

NEXT STEPS

Meeting #4 Agenda:

- Appeal Process
- Reserve time for step 2: What should be the primary domains for performance measurement and accountability for regions?
- Third table will be handled by the consultant's risk. Approve/disapprove.
- LL to send information to Joanna.
- Continue to move on issues.

For more information:

Handouts and meeting information for each workgroup will be made available at: http://www.dhs.state.ia.us/Partners/MHDSRedesign.html

Website information will be updated regularly and meeting agendas, minutes, and handouts for the six redesign workgroups will be posted there.